DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

# TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

**HEALTH CARE FINANCING ADMINISTRATION**

1. TRANSMITTAL NUMBER: 01-02

2. STATE: Kentucky

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2001

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Section 1932 of the Act

7. FEDERAL BUDGET IMPACT:
a. FFY 2001 $ 1.73 million
b. FFY 2002 $ 1.75 million

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Section 1.6
Pages 9c through 9i

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Same

10. SUBJECT OF AMENDMENT:
KentAC enrollments

GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Reviewed delegated to Interim Commissioner Department for Medicaid Services

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Ellen Hesen

14. TITLE: Interim Commissioner
Department for Medicaid Services

15. DATE SUBMITTED: 3/[illegible]/01

16. RETURN TO:
Sharon A. Rodriguez, Manager
Policy Coordination Branch
Department for Medicaid Services
275 East Main Street 6tA
Frankfort, Kentucky 40621

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:
March 30, 2001

18. DATE APPROVED:
June 13, 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
January 1, 2001

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Eugene A. Grasser

22. TITLE: Associate Regional Administrator
Division of Medicaid and State Operations

23. REMARKS:

FORM HCFA-179 (07-92)

*Instructions on Back*

Section 1.6 State Option to Use Managed Care

This program is called the Kentucky Patient Access and Care System (KenPAC). All Medicaid recipients are required to enroll with a primary care case manager (PCCM) except those as described in Sections B and D below. The objectives of this program are to reduce costs, reduce inappropriate utilization, improve quality of care, and assure adequate access to care for Medicaid recipients. The purpose of KenPAC is to allow Medicaid recipients to select a primary care case manager to provide, through an ongoing patient/physician relationship, primary care services and referral for all necessary specialty services. KenPAC will operate in all counties of the state except in those geographical areas participating in an approved 1115 waiver or those counties that do not have an adequate number of primary care case managers participating in KenPAC.

I. Assurances

A. The State assures that all requirements of sections 1932 and 1905(t) of the Social Security Act will be met for the primary care case management program, KenPAC.

B. The following populations will be exempt from enrollment in KenPAC:

1. Individuals who meet the eligibility requirements for receipt of both Medicaid and Medicare benefits ("dual eligibles");

2. An American Indian who is a registered member of a Federally-recognized tribe; and

3. Children under 19 years of age who are:

a. Eligible for SSI under Title XVI;
b. Described in section 1902(e)(3) of Title XIX of the Social Security Act;
c. Receiving foster care or adoption assistance under part E of title IV;
d. Receiving foster care or otherwise in an out-of-home placement; or
e. Receiving services through a family-centered, community-based, coordinated care system receiving grant funds under 42 USC 501(a)(1)(D).

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Children receiving services through a family-centered, community-based, co-ordinated care system receiving grant funds under 42 USC 501(a)(1)(D) are children receiving comprehensive services including case management through the Commission for Children with Special Health Care Needs of the Cabinet for Health Services.

As many children as possible will be identified through the Medicaid Management Information System (MMIS) through Aid Category. Others receiving comprehensive services will be identified by the Commission for Children with Special Health Care Needs. Upon confirmation of enrollment by the program, an exclusion code will be placed on the child's file in the Kentucky Automated Management Eligibility System (KAMES) that will not allow the child to be enrolled in KenPAC. At the time of annual enrollment, the Department for Medicaid Services will confirm that the child is still receiving comprehensive services from the Commission for Children with Special Health Care Needs and the exclusion will be continued.

If the Commission for Children with Special Health Care Needs identifies any child for whom they are providing comprehensive services in that program who is enrolled in KenPAC, arrangements will be made to immediately disenroll the child from KenPAC with the appropriate exclusion code. Services provided to such children will not require authorization. Providers will be given emergency authorizations for claims processing until the child can be disenrolled.

C. Enrollment in KenPAC is limited to the following target group of recipients:

1. AFDC Related;
2. Family Related;
3. Poverty Related Women and Children;
4. Kentucky Children's Health Insurance Program (KCHIP);
5. SSI recipients age nineteen (19) and above;
6. SSI-Related; and
7. State Supplementation.

D. Recipients are not enrolled in KenPAC if they:

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1. Participate in the Kentucky Health Insurance Premium Payment Program (KHIPP);
2. Are residing in a nursing facility;
3. Are residing in an intermediate care facility for the mentally retarded;
4. Are residing in a psychiatric hospital or psychiatric residential treatment facility;
5. Are a hospice recipient;
6. Are enrolled in another managed care program;
7. Have an eligibility period that is only retroactive;
8. Are eligible as medically needy (spenddown);
9. Are in Administrative Hearing Status Related to KenPAC;
10. Are a Lock-In recipient;
11. Are Home and Community-Based Waiver recipients;
12. Are Qualified Medicare Beneficiaries (QMB);
13. Are Qualified Disabled Working Individuals (QDWI);
14. Are Specified Low-Income Medicare Beneficiaries (SLMB); or
15. Are an alien who is approved for time limited Medicaid due to an emergency medical condition.

E. The PCCM shall be responsible for managing the following services: primary care services and physician specialty referrals, hospital inpatient and outpatient services, ambulatory surgical center services, home health services, primary care center services and rural health clinic services, advanced registered nurse practitioner services if it is a nonexcluded service provided by an ARNP who is not the PCCM, durable medical equipment and medical supplies, laboratory and radiological services, pharmacy services for prescriptions issued by the PCCM, gynecology services, and physical therapy, occupational therapy, and speech therapy. The physician services element shall not include services provided by an ophthalmologist or optometrist, psychiatrist, or an oral surgeon.

F. KenPAC recipients are free to seek the following services without having to be prior authorized by the PCCM:

1. Services provided by a dentist or oral surgeon;

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2. A mental health service provided by a psychiatrist, psychiatric facility, clinic, ARNP who has a psychiatric specialty area or other mental health provider;
3. A covered medical service provided by an ophthalmologist or an optometric service and eyeglasses;
4. A maternity care service including prenatal care, delivery, and postpartum care;
5. A service provided by a podiatrist;
6. A school-based service;
7. General medical transportation services or emergency or non-emergency ambulance services;
8. EPSDT services;
9. Services provided by the Kentucky Early Intervention Services program;
10. Services provided by an audiologist or hearing aid dealer and hearing aids;
11. Non-physician services provided through the Medicaid Preventive Services Program by a local public health department;
12. Chiropractic services;
13. Newborn care services;
14. Services provided through Specialized Services Clinics;
15. A Health Access Nurturing Development Service (HANDS); and
16. Family planning services.

G. The primary care case manager must provide or arrange PCCM coverage for services, consultation, or approval of referrals 24 hours per day, 7 days per week. The primary care case manager shall be available 24 hours per day, 7 days per week through access by telephone to a live voice (the PCCM, an employee of the PCCM or an answering service). An answering service would be acceptable if the recipient calls the answering service and is able to speak immediately to a person or is forwarded to another telephone number manned by a live person. In both situations, the answering service must notify the primary care case manager or designated representative of the recipient's call.

H. The primary care case manager shall not refuse an assignment or disenroll a participant or otherwise discriminate against a participant solely on the basis of age, sex, race, physical or mental disability, national origin, or type of

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illness or condition except when that illness or condition requires treatment by another provider type.

I. Access to medically necessary emergency services shall not be restricted. Emergency care means covered inpatient and outpatient services furnished by a qualified provider that are needed to evaluate or stabilize an emergency medical condition that is found to exist using the prudent layperson standard; and emergency ambulance transport. Emergency medical condition means a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. Prudent layperson standard means the criterion used to determine the existence of an emergency medical condition whereby a prudent layperson determines that a medical condition manifests itself by acute symptoms of sufficient severity (including severe pain) such that the person possessing an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. Treatment in emergency situations does not require prior authorization by the PCCM or the KenPAC program.

J. Urgent care, if medically necessary, may be provided without prior authorization from the PCCM if the PCCM can not be contacted. Urgent care means a covered service that, while not required on an emergency basis, is required promptly to prevent substantial deterioration of the recipient's health status and for which the failure to provide service promptly would reasonably be anticipated to cause substantial harm to the recipient. For purposes of this definition, promptly shall mean the same day or within 48 hours based on a PCCM's assessment of urgency of need.

K. In each county where KenPAC is mandatory, recipients will have a choice of at least two (2) PCCMs participating in the program. Recipients will be required to select a PCCM from participating PCCMs in his or her county of

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residence or, at recipient's option, any adjacent county. Individuals who do not make a voluntary selection within 30 days, will be assigned a primary care case manager within their county of residence by the Medicaid program as described in section M below.

L. Recipients will be permitted to disenroll with a PCCM at any time for cause. Recipients will also be allowed to request a change in PCCM during the first 90 days of enrollment and at least every 12 months (annual open enrollment period) thereafter without cause. At least 60 days prior to the expiration of the enrollment period, all recipients will be notified of their ability to disenroll/change PCCMs during the annual open enrollment period.

M. The State assures that default enrollment will be based upon maintaining prior provider-patient relationships whenever possible. The mandatory assignment process uses an algorithm which considers age, sex, place of residence, PCCM availability, and equitable PCCM distribution. The recipient will be notified of his or her assignment to a PCCM.

N. The State assures that information provided to recipients on PCCMs, recipient rights and responsibilities, grievance and appeal procedures, covered items and services, and benefits not covered will be in an easily understood format. The State shall annually provide to recipients information in chart-like form that identifies the managed care entities that are available including the benefits, service area, quality and performance indicators of each entity to the extent possible.

II. Methodology and Process

Recipients will be able to select a PCCM from a list of available PCCMs in their county as well as those in contiguous counties. If the recipient wishes to remain with a primary care case manager with whom a patient/physician relationship is already established, the recipient is allowed to do so based on medical need. If a voluntary selection is not made within 30 days, the Medicaid program shall assign a primary care case manager in accordance with the procedures outlined in section M above.

III. Contracts with Primary Care Case Managers

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The following provider types can contract with the Department for Medicaid Services to provide primary care case management services: general practitioners, family practitioners, pediatricians, internists, obstetricians, gynecologists, and advanced registered nurse practitioners. Specialty physicians may participate if Medicaid determines that their participation is in the best interests of both the recipient and the KenPAC system and if the specialist agrees to perform all the duties and responsibilities required of primary care case managers.

All participating primary care case managers shall be required to sign a KenPAC participation agreement in addition to the standard Medicaid provider agreement and shall be bound by its terms and conditions. Each PCCM shall be required to specify the number of recipients the PCCM is willing to serve as primary care case manager. Unless circumstances exist which require the department to authorize a higher quota for a PCCM to ensure adequate coverage in an area, the maximum shall be 1,500 recipients per primary care case manager.

The State assures that the contracts with primary care case managers meet all the terms required under section 1905(t)(3). Reimbursement for the PCCMs is on a fee-for-service schedule with a monthly case management fee. Reimbursement to PCCMs that are cost-based is the amount determined by the cost report with a monthly case management fee. Each primary care case manager shall receive a monthly case management fee ($4.00 per member/per month) for each KenPAC recipient assigned.

PCCMs that agree to accept a minimum of twenty (20) additional KenPAC recipients above the PCCM's enrollment as of December 31, 2000, shall be eligible to receive a one-time-only incentive payment. The PCCM must agree to accept the additional members for the lessor of the remaining term of the PCCM's current provider agreement or a period of twelve (12) consecutive months. The incentive payment shall be in the amount of fifty (50) cents per member per month for the total of all recipients enrolled with the PCCM and shall be paid for the months of January through June, 2001.

For a KenPAC clinic with 1,000 or more enrolled recipients, the clinic shall be eligible to receive an incentive payment if it agrees to accept a minimum of fifty (50) additional KenPAC recipients above the clinic's enrollment as of December 31, 2000.